Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CHEOR J KIM, MD
3100 TIMMONS LANE #250
HOUSTON, TX 77027

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-2418-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER REFUSES TO PAY FULL AMOUNT DUE FOR SERVICES RENDERED EVEN AFTER A REQUEST FOR RECONSIDERATION WAS SUBMITTED."

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "4. The requestor coded the "Issues similar to those described…" i.e. the second determination with W6 when it should have been W9. For this reason Texas Mutual denied payment. The requestor coded 99456-W7 correctly and was paid the MAR of $250.00. 5. The requestor presented no substantive explanation with its request for reconsideration to cause Texas Mutual to alter its determination."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 22, 2010	99456-RE-W6	$500.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated January 26, 2011
   - CAC-4 – THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.
   - CAC-B22 THIS PAYMENT ADJUSTED BASED ON THE DIAGNOSIS.
   - 732 – ACCURATE CODING IS ESSENTIAL FOR REIMBURSEMENT. CPT AND/OR MODIFIER BILLED INCORRECTLY. SERVICES ARE NOT REIMBURSABLE AS BILLED.
   - 907 – ONLY TREATMENT RENDERED FOR THE COMPENSABLE INJURY IS REIMBURSABLE NOT ALL CONDITIONS INDICATED ARE RELATED TO THE COMPENSABLE INJURY.

   Explanation of benefits dated March 10, 2011
   - CAC-193 – ORIGINAL PAYMENT DECISION BEING MAINTAINED UPON REVIEW. IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - CAC-4 – THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.
   - CAC-B22 THIS PAYMENT ADJUSTED BASED ON THE DIAGNOSIS.
   - 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824.
   - 732 – ACCURATE CODING IS ESSENTIAL FOR REIMBURSEMENT. CPT AND/OR MODIFIER BILLED INCORRECTLY. SERVICES ARE NOT REIMBURSABLE AS BILLED.
   - 907 – ONLY TREATMENT RENDERED FOR THE COMPENSABLE INJURY IS REIMBURSABLE NOT ALL CONDITIONS INDICATED ARE RELATED TO THE COMPENSABLE INJURY.

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement for disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The respondent denied the billing with reason code "CAC-B22 - THIS PAYMENT IS ADJUSTED BASED ON THE DIAGNOSIS" and "907 – ONLY TREATMENT RENDERED FOR THE COMPENSABLE INJURY IS REIMBURSABLE. NOT ALL CONDITIONS INDICATED ARE RELATED TO THE COMPENSABLE INJURY." As, the respondent did not clarify or otherwise address or uphold the CAC-B22 or 907 claim adjustment codes in the dispute resolution response, the Division will review the billing per the applicable Division rules and medical fee guideline in 28 Texas Administrative Code §134.204 with a review of supporting documentation.
2. The requestor was ordered by the Division to perform an examination to determine whether the employee's disability were a direct result of the work related injury and also to determine if there is an injury resulting from the claimed incident. 28 Texas Administrative §134.204 (I)(1) (F) states: "Issues similar to those described in subparagraphs (A) - (E) of this paragraph shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier "W9."" The requestor billed with an incorrect –W6 modifier which is only used when determining the extent of the injured worker's injury according to 28 Texas Administrative §134.204 (i)(2)(C) which was an unrequested service.
3. The requestor did not bill the appropriate modifier -W9, therefore requestor is not entitled to reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 27, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.
Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.